

Evaluation of the national eye care coordination programme in Zambia

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Abstract: In 2008, an evaluation of the National Eye Care Coordination programme in Zambia was undertaken, after just over 1 year of its existence. The evaluation was undertaken to assess the performance of the programme since it was created as a stand-alone project from its previous operation in the integrated system. Integrating health services has become a common term especially in developing countries where it is believed that bundling together of resources (financial and human resources) is more effective and resource conserving. The evaluation, of the Eye Care Programme in Zambia after turning it into a stand-alone programme shows results that can be compared to the time it was in an integrated system.

Keywords: Evaluation, Eye Care, Integration, Stand-Alone

1. Introduction

There has been a long-standing debate on whether health programmes/projects should be integrated (also known as horizontal system) or left to run as stand-alone initiatives (also known as vertical programmes).

A number of authors have given opinions against integrated programmes. Studies were done on health projects in Central America and Africa to determine their sustainability (possibility of continuing to exist after donor funding) those in Africa had a less chance of being sustained. It was recommended that all new initiatives should be integrated into fully established administrative structures, but not necessarily into other disease programmes¹. At implementation level, another study found that integration fails to improve hospitals' economic performance². Another study stated that sustainability of programmes arises if there is targeting of problems (drivers) to be addressed and not necessarily integrating³. In Zambia, Ghana and Bangladesh, it was found that integration can cause problems of performance due to the reorganization of technical responsibilities, rationalization of procurement arrangement, shortages of funding, changes in priorities and changes in government and donor relationships⁴.

On the other hand, others have spoken in favor of integration. One study showed that in the long term, integrated programmes could be better as they can lead to

economies of scale, risk-bearing ability, transaction costs, and the capacity for innovation in methods of managing care⁵. Other concludes that the benefits of vertical integration are based poorly adapted models and simply copied from other sectors of the economy that are not compatible with health⁶. Others say that integration works well if one is integrating clinical, public health and community services and not necessarily integrating public health services amongst each other⁷ whilst other only recommended integration amongst public health organizations and not programmes⁸. For diseases that seemingly receive little attention from authorities, some recommend that they should be integrated into better resourced programmes such HIV/AIDs, Tuberculosis and Malaria and claim that it could result into mutual benefit and the benefit of the entire health system⁹. Some researchers have observed that there has been increased financial support to the health sector in developing countries estimated at 26% between 1997 and 2002, from \$6.4 billion to \$8.1 billion but this investment has been allocated towards disease-specific projects (termed 'vertical programming') rather than towards more broad-based improvements, therefore, proposing for investment in horizontal programmes¹⁰.

There is also a call to planners and policy makers to see

the merits of both vertical and horizontal programmes them make decisions based on trade-offs. They say that various factors influence the choice of mode of delivery of health services, for example, public officials in developing countries would consider factors such as geographical demands of health services, poverty numbers and distribution, limited resources (human and financial) and sometimes long term sustainability of programs and political dynamics in a country in making a decision on the mode of delivery of services. Donors would prefer vertical programmes in order to attain quick results for them to show to their taxpayers in their countries of origin¹¹.

Other views are that there is no need to compel policy makers to choose between vertical and horizontal are the two are not mutually exclusive and can therefore co-exist. Some conclude that expanding access to priority health services requires the concerted use of both modes of delivery, according to the capacity of health systems as it changes over time¹². It has also been noted that the presence of both integrated and non-integrated programmes in many countries suggests there may be benefits to either approach, and that there are few instances where there is full integration of a health intervention or where an intervention is completely non-integrated, insisting that what exists are highly heterogeneous picture both¹³.

The state of eye care in Africa is described as poor relative to other part of the world, citing poor practitioner-to-patient ratios, absence of eye-care personnel, inadequate facilities, poor state funding and a lack of educational programs are the hallmarks of eye care in Africa, with preventable and treatable conditions being the leading cause of blindness¹. Africa has 19 per cent of the world's blindness. In a certain survey in Zambia¹⁵, 2.29% of people over the age of 50 were found to be blind with another report stating that about one in 40 Zambians is blind³. The Government of Zambia has made a lot of effort to address this problem. In 2008, the National Eye Care and Coordination Programmes (NECCP) in the Ministry of Health of Zambia^{17,18,19} was evaluated after about one year of its existence. Previously Eye Care was not a stand-alone programme but was integrated into Clinical Care and Diagnostics, which is a conglomerate of various disease intervention entities. There is a school of thought that integration saves resources and maximizes the impact of various initiatives. The World Health Organisation^{20,22} defines Integrated service delivery as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."

The National Eye Care Coordination programme was set up mainly to respond to the need to prevent blindness in the country^{17, 18 & 19}. Though preventable in most cases, blindness is a major health problem in Zambia¹⁶, with associated economic and social consequences.

Among the main features in that existed in the integrated system, the Eye Care Programme had no specific budget line as its services were funded from the general disease control and health service delivery budgets²². The Eye Care

Programme also did not have any full time management staff in the Ministry of Health and therefore, matters of Eye Care were dealt with by the various staff handling various other disease interventions.

In the on-going brainstorming on the Health Post 2015 Development Agenda²³ there have been calls for integrated programmes as opposed to stand-alone. Therefore, the results of the evaluation of the National Eye Care Coordination Programme in Zambia can contribute to the discussion on integrated versus stand-alone, for the Post 2015 Development Agenda.

2. Methodology

2.1. The Approach

The evaluation was conducted using the Theory of Change approach which is a representation of how the initiative (National Eye Care Coordination Programme) was expected to lead to results based on the assumptions that were made. The results of the evaluation of this standalone programme, were compared to previous years when it operated within an integrated system.

2.2. Data Collection

Data collection was done by reviewing records, key informant interviews and observations. The review of records mainly involved three documents; the National Eye Care Coordination Project agreement, the National Eye Care Coordination strategic plan and the National Eye Care Coordination operation plan. Country disease statistics and financial records were also reviewed. The Theory of Change was developed from the National Eye Care Coordination Project agreement (Memorandum of Understanding)¹⁷ signed between the Zambian Government and their donors, mainly Sight Savers International.

2.2.1. Informants

The informants included the focal point person in Ministry of Health Headquarters, staff from the District Health Management Teams, Provincial Health Management Teams, the Child Health Unit, Nutrition Unit, University Teaching Hospital Eye Unit the Chainama College, the University of Zambia School of Medicine and Sight Savers International.

2.2.2. Observers

Observations were made at the Lusaka DHMT service delivery points, UTH eye unit and the project coordinator's office. The observations included verification of presence/absence of staff, equipment and workflows/work processes. The service delivery point sites were selected by convenience sampling.

2.2.3. Observations

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3. Results

The evaluation revealed that since the inception of this eye coordination programme as a stand-alone initiative, resources for eye care in Zambia have increased as the donors (and other stakeholders) have shown more willingness to invest in it. The donors included non-profit organizations such as Sight Savers International, commercial partners such as Standard Chartered Bank. Other stakeholders included their government counterparts such as the Ministries such as Community development and Energy & Water development who had provided “in-kind” support. The partners interviewed attributed their interest in the new programme (as opposed to the integrated one) to clear objectives and less ambiguous results that make it easier for them to account for the resources invested and that it gives more visibility for their initiatives.

The establishment of the Eye Care program as a stand-alone entity had also yielded about four more scholarships for general practitioners to specialize in ophthalmology. The programme had also managed to motivate and retain the newly trained surgeons (4 at the time of evaluation) with opportunities for Continuing Medical Education (CME).

It was further noted that since it became standalone

programme, there has been more financial and human resources to undertake more outreach programme where on-sight surgical procedures are undertaken especially for cataract. It was reported that in some areas, the outreach services had increased from one to as much three times per year which led to the number of surgical operations countrywide to increasing from 7,000 to 10,000 per year¹¹, which accounts for over 40% increase.

Changes in costs of operations were also noted. The most significant change in service delivery was the increase in outreach activities or “Eye Camps” where the average monthly expenditure increased from 96,096 United States Dollars to 136,488, representing an increase of about 42%. Although the costs of operation had increased by over 40%, it had resulted in more surgical operations with associated increased number of blindness cases prevented, with a likely positive impact on the Quality Adjusted Life Years (QALYS) and Disability Adjusted Life Years (DALYS), thereby, justifying the increase in costs.

Although close to one in 40 Zambians is blind, most of these causes of blindness can be described as being preventable. One in six Zambian children suffers from trachoma, an eye infection that can lead to blindness and that spreads through physical contact or by flies. Treatment for trachoma is not easy to come by in Zambia, a country of about 13 million people with only about 800 doctors and a dozen ophthalmologists. Therefore, the increased operations through increased outreach activities that yielded an additional 3,000 operations, responded to a need in Zambia.

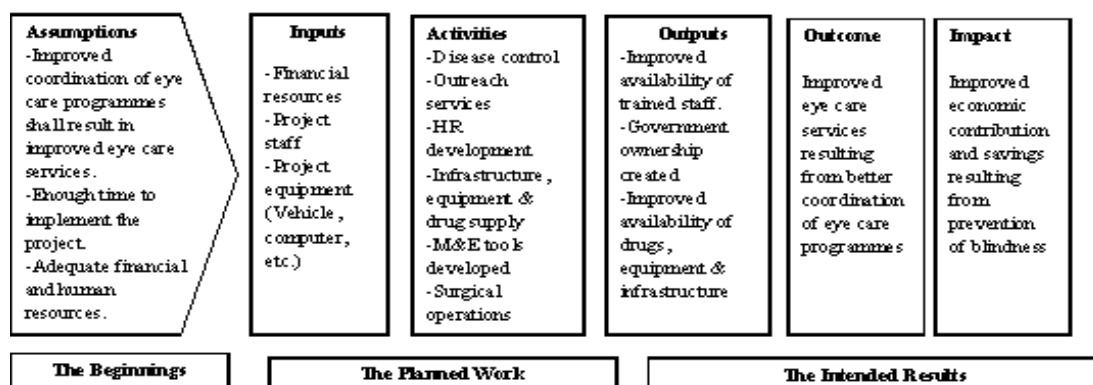


Figure 1. Diagram showing the “Theory of Change” for the evaluation of the NECCP in Zambia.

4. Discussion

Although the programme was based on centralized staff, their mode of operation to increase coverage was by undertaking outreach programmes that are commonly called “Eye camps”, throughout the country. The increased financial and human resources enabled the programme to undertake more frequent Eye Camps, thereby increasing the number of annual eye operations by 3,000.

Most policy practitioners believe that packaging health service areas in groups, under one budget-line and managed by multi-tasked staff saves resources including time and

finances. However, in such systems some more influential disease programmes such as HIV/AIDS and Malaria can thrive and overshadow others such as Eye Care.

The results of the evaluation of the Eye Care programme in Zambia can reopen the debate on whether a stand-alone programme can achieve more impact, increase resource mobilization and not deter sustainability as widely believed. Partners, donors and political leaders and other stakeholders who are keen on demonstrating results are likely to favor a standalone programme because of its clear outputs.

However, just like in most evaluations, the challenges of attribution should be taken into consideration. Further evaluations, as the standalone programme continues to exist,

shall reveal more substantive information and determine whether all these achievements should be attributed to the stand-alone approach.

The results of the evaluation of this successful stand-alone programme could mean that integrated programmes do not guarantee positive results and on the other hand it could mean that stand alone programmes are not as destructive as previously thought. Such results were unlikely to be seen if the programme was still in an integrated system where there are usually disaggregated, ambiguous and long-term results. The programme has continued to undertake an average of 10,000 operations per year to prevent blindness with most of the funding coming from Government.

References

- [1] Bossert, Thomas J. (1990). Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa. *Social Science & Medicine*, 30 (9), p. 1015–1023. DOI: 10.1016/0277-9536(90)90148-L
- [2] Burns, Lawton R. and Pauly, Mark V. (2002). Integrated Delivery Networks: A Detour On The Road To Integrated Health Care? *Health Affairs*, 21 (4), p. 128-143. doi:10.1377/hlthaff.21.4.128
- [3] Gruen, R., Elliott, J., Nolan, M., Lawton, P., Parkhill, A., McLaren, C. and Lavis, J. (2008). Sustainability science: an integrated approach for health-programme planning. *The Lancet*, 372 (9649), p. 1579-1589. Available from: <http://www.sciencedirect.com/science/article/pii/S0140673608616591> [Accessed: 28th June 2014]
- [4] Brown, A. (2001). Integrating vertical health programmes into sector wide approaches: experiences and lessons. UNSPECIFIED. (Unpublished). Available from: <http://ihi.eprints.org/441/> [Accessed: 28th June 2014]
- [5] Robinson, J. C. and Casalino, L. P. (1996). Vertical integration and organizational networks in health care. *Health Affairs*, 15 (1), p. 17-22. doi: 10.1377/hlthaff.15.1.7
- [6] Walston, S., Kimberly, J. and Burns, L. (1996). Owned vertical integration and health care: Promise and performance. *Health Care Management Review*, 21 (1). Available from: http://journals.lww.com/hcmrjournal/Abstract/1996/02110/Owned_vertical_integration_and_health_care_9.aspx [Accessed: 28th June 2014]
- [7] Plescia, M., Koontz, S. and Laurent, S. (2001). Community assessment in a vertically integrated health care system. *American Journal of Public Health*, 91 (5), p. 811-814. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446692/> [Accessed: 28th June 2014]
- [8] Axelsson, Runo and Axelsson, Susanna, Bihari (2006). Integration and collaboration in public health—a conceptual framework. *The International Journal of Health Planning and Management*, 21 (1), p. 75-88.
- [9] Gyapong, J., Gyapong, M., Yellu, N., Anakwah, K., Amofah, G., Bockarie, M. and Adjei, S. (2010). Integration of control of neglected tropical diseases into health-care systems: challenges and opportunities. *The Lancet*, 375 (9709), p. 160-165. Available from: <http://www.sciencedirect.com/science/article/pii/S0140673609612496>
- [10] De Maeseneer, J., van Weel, C., Egilman, D., Mfenyana, K., Kaufman, A. and Sewankambo, N. (2008). Strengthening primary care: addressing the disparity between vertical and horizontal investment. *British Journal of General practice*, 58 (546), p. 3-4. 10.3399/bjgp08X263721 *BJGP*
- [11] Msuya, Joyce (2006). Horizontal and Vertical Delivery of Health Services: What Are The Trade Offs? The World Bank. Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2003/10/15/000160016_20031015125129/Rendered/PDF/269420Msuya1WDR1Background1paper.pdf [Accessed: 28th June 2014]
- [12] Oliveira-Cruz, V., Kurowski, C. and Mills, A. (2003). Delivery of priority health services: searching for synergies within the vertical versus horizontal debate. *Journal of International Development*, 15 (1), p. 67-86. DOI: 10.1002/jid.966
- [13] Atun, R., de Jongh, T., Secci, F., Ohiri, K. and Adeyi, O. (2009). A systematic review of the evidence on integration of targeted health interventions into health systems. *Health Policy and Planning*, 25(1), p. 1-14. doi: 10.1093/heapol/czp053
- [14] Naidoo, K. (2007). Poverty and blindness in Africa. *Clin Exp Optom*, 90(6), p. 415-21 Available from: <http://www.ncbi.nlm.nih.gov/pubmed/17958563> [Accessed: 29 October 2013]
- [15] Lindfield R, Griffiths U, Bozzani F, Mumba M, Munsanje J (2012) A Rapid Assessment of Avoidable Blindness in Southern Zambia. *PLoS ONE* 7(6): e38483. doi:10.1371/journal.pone.0038483. Available from: <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0038483> [Accessed: 29 October 2013]
- [16] Zambia: Blindness Prevention Fund (2009). Geneva Global: Performance Philanthropy. Available from: http://www.capitalforgood.org.uk/documents/Geneva-Global_Zambia_Blindness_Prevention_Fund_2009.pdf [Accessed: 29 October 2013]
- [17] Republic of Zambia-Ministry of Health (2007). The National Eye Care Coordination Programme Agreement of Zambia. Directorate of Clinical Care and Diagnostics.
- [18] Republic of Zambia-Ministry of Health (2007). The National Eye Care Coordination operation plan. Department of Clinical Care and Diagnostics.
- [19] Republic of Zambia-Ministry of Health (2007). The National Eye Care Coordination strategic plan. Directorate of Clinical Care and Diagnostics.
- [20] World Health Organization (2008). Integrated Health Services—What and Why? Technical Brief No.1. Available from: http://www.who.int/healthsystems/service_delivery_techbrief1.pdf [Accessed: 18 April 2013]
- [21] World Health Organization (2012). HIV operational plan 2012-2013: WHO's support to implement the Global health sector strategy on HIV/AIDS. WHO Library Cataloguing-in-Publication Data. Available from: http://whqlibdoc.who.int/publications/2012/9789241503709_eng.pdf [Accessed: 18 April 2013]

- [22] Republic of Zambia, Ministry of Health annual budgets
- [23] World Health Organization (2012) Informal Member State Consultation on Health in the Post 2015 Development Agenda. Executive Board Room. Available from: http://www.who.int/topics/millennium_development_goals/post2015/summary_informal_consultation_memberstates_20121214.pdf [Accessed: 18 April 2013]
- [24] Republic of Zambia-Ministry of Health (2007). Health Management Information Systems (HMIS). Directorate Planning.